

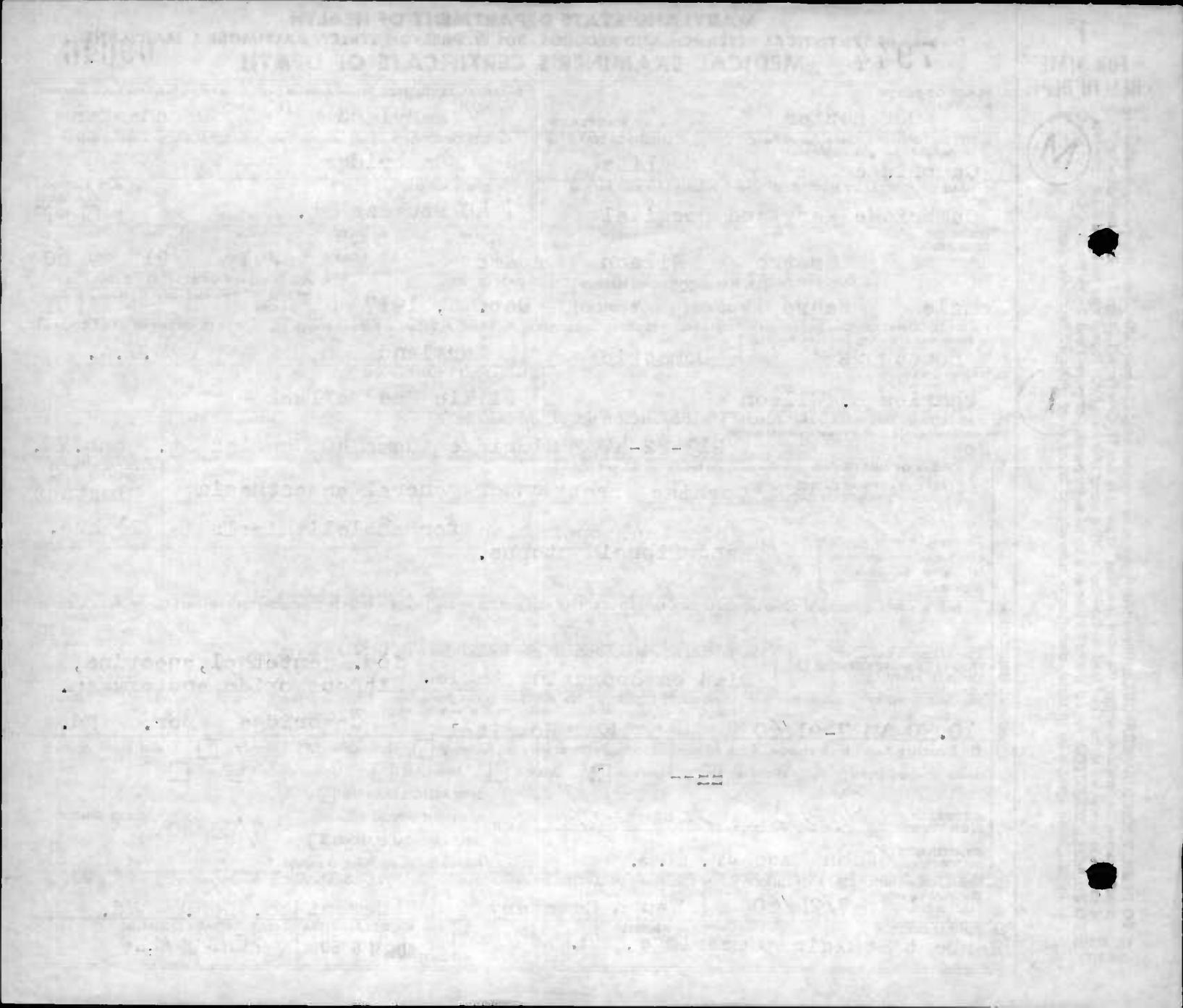
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7944 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09046

1. PLACE OF DEATH e. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		a. STATE Maryland		b. COUNTY Dorchester			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					
3. NAME OF DECEASED (Type or print) Gretha		First	Middle	Last	4. DATE OF DEATH July 21 1960	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1917	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR 42 yrs.	IF UNDER 24 HRS. Months Deyrs Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles E. Wilson		14. MOTHER'S MAIDEN NAME Lillie Mae Mollock							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank and date of service) No		16. SOCIAL SECURITY NO. 213-22-4762		17. INFORMANT Eldridge Adams		Address 40 Douglas St. Camb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH Instant	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest under general anaesthesia									
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. 154X									
DUE TO (b) Abdominal operation for cholelithiasis and fibroid uterus.								2½ hrs.	
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Sod. pentothal, anectine, Died on operating table. Nitrous oxide and oxygen.							
20c. TIME OF INJURY Hour a.m. 10.30 AM		Month, Day, Year 7-21/60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Cambridge	(County) Dor.	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Mace Jr. M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						7/23/60	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
		Address (Street, city, town, or county) Cambridge, Dor. Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/60	22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery	22d. LOCATION (City, town, or country) (State) Cambridge, Dor. Md.					
23. FUNERAL DIRECTOR Herbert StClair Cambridge, Md.		ADDRESS						24a. REC'D BY REGISTRAR AUG 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07927

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 4 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN NELLIE ADENT		4. DATE OF DEATH JULY 2, 1960	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER ADENT		14. MOTHER'S MAIDEN NAME KATHERINE SLAVINSKY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 357-14-2203	
17. INFORMANT HOSPITAL RECORD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE UTERUS			
174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) GENERAL METASTASES	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1957, to JULY 2, 1960, that (II) (we) lost saw the deceased alive on JULY 2, 1960, and that death occurred at 708 M, from the causes and on the date stated above.			
22a. SIGNATURE Ettore De Filippis		22b. DATE SIGNED JULY 2, 1960	
22c. PHYSICIAN'S NAME (Type) ETTORE DE FILIPPIS		22d. ADDRESS EASTERN SHORE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/7/60	
23c. NAME OF CEMETERY OR CREMATORI St. Casimir Cemetery		23d. LOCATION (City, town, or county) (State) Worth, Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR ADDRESS DATE JULY 8 '60	
		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07928

Reg. Dist. No.

7945

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Dorchester MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cambridge	40 yrs.	Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
154 Washington Street		154 Washington Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
William (Will)		E.	Banks
4. DATE OF DEATH		Month	Day
		July	11
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
		66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Laborer		Food-Packing	Alexanderia, Va.
12. CITIZEN OF WHAT COUNTRY?			
		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Banks, Sr.		Clara Banks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
Yes WW I		217-10-8062	Lillie Banks, Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Heart Disease	
420			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b)		Cardiac Decompensation	
DUE TO			
(c)			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from June 1, 1959, to July 11, 1960, that I last saw the deceased alive on July 11, 1960, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED 7-14-60	
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>			
PHYSICIAN'S NAME (Type)		M.D. 227 Pine St-Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/1960	22c. NAME OF CEMETERY OR CREMATORIUM Betzel Cemetery
22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Neibor M. S. Fassett Jr.</i>		24a. REC'D BY REGISTRAR DATE JUL 22 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

NAME OF DECEASED	
MURKIN, MARY	
ADDRESS	
1015 E. 36TH ST., BALTIMORE, MD.	
AGE AT DEATH	
60 YEARS	
SEX	
FEMALE	
CAUSE OF DEATH	
CANCER OF LIVER	
TIME OF DEATH	
10:00 A.M.	
PLACE OF DEATH	
HOME	
TIME OF ISSUANCE	
APRIL 15, 1958	
SIGNATURE	
DR. JAMES H. COOPER	
SIGNATURE	
DR. JAMES H. COOPER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

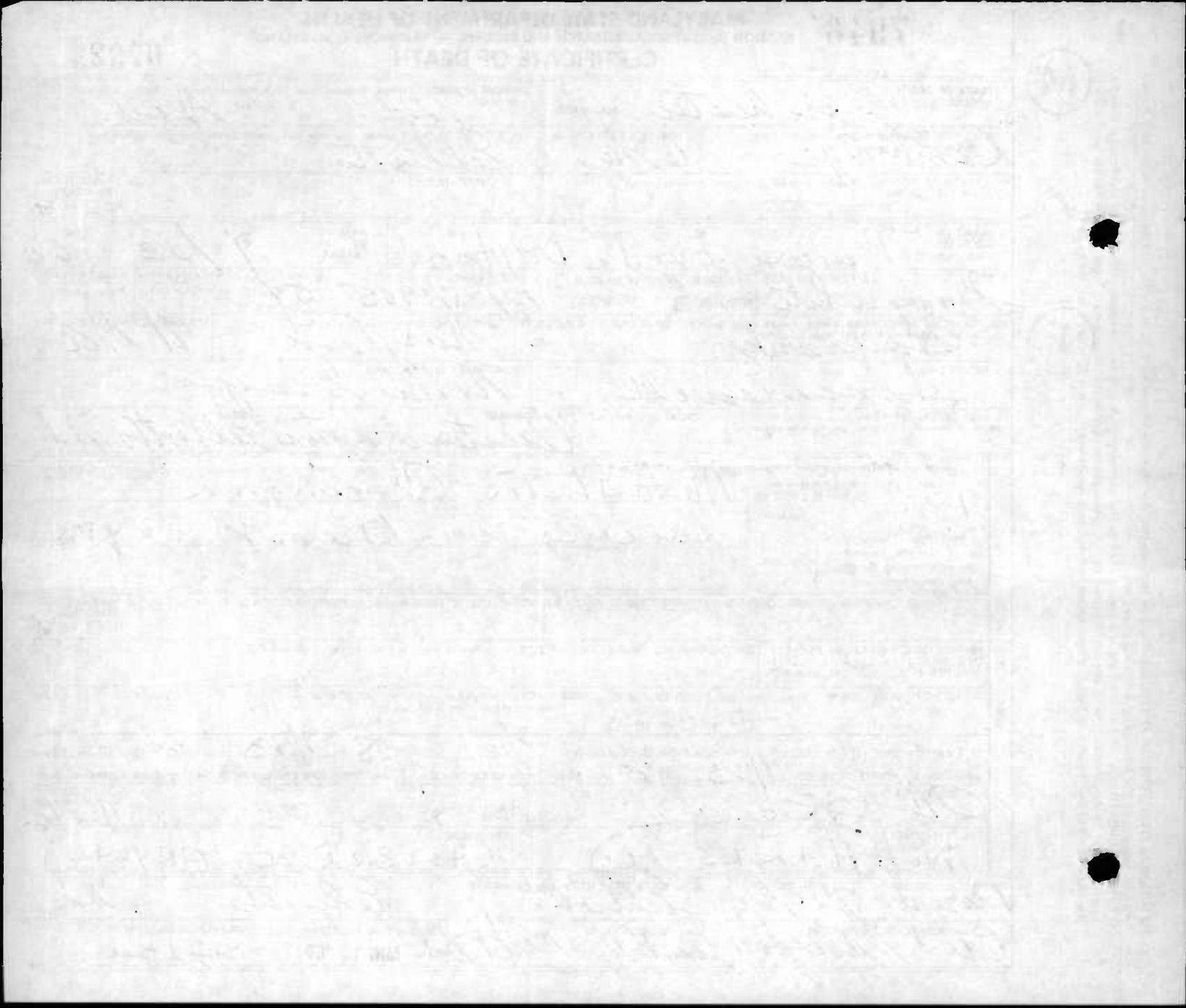
7946

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07929

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Chester</i> MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Cambridge 6 mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <i>Elliotts</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Pauline</i>	Middle <i>Ewell</i>
		Last <i>Dayton</i>	4. DATE OF DEATH Month <i>7</i> Day <i>23</i> Year <i>1960</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>12/25/1905</i>		9. AGE (In years 1st birthday) yrs. <i>57</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stockwoman</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Swain Ewell</i>	
14. MOTHER'S MAIDEN NAME <i>Nora Gray</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Austin Dayton, Elliotts, Md.</i>	18. CAUSE OF DEATH [Enter only one cause, pointing far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>170X</i> DUE TO <i>Metastatic Carcinoma</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <i>Lacunoma Breast</i> (c) <i>2 yrs</i> INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>St. Marys</i> (County) <i>St. Marys Co.</i> (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>5/10</i> to <i>19/58</i> to <i>7/23</i> , 1960, that (I) (we) last saw the deceased alive on <i>7/23</i> , 1960, and that death occurred at <i>77 M.</i> from the causes and on the date stated above.		22d. SIGNATURE <i>O.H. Roberts</i> 22b. DATE SIGNED <i>7/25/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.H. Hawks M.D.</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Cambridge, MD 21613</i>
23d. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> <i>7/25/60</i>		23e. DATE THEREOF <i>7/25/60</i>	23f. NAME OF CEMETERY OR CREMATORIAL <i>Elliotts</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Willoughby, East New Market, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>AUG 1 '60</i>
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07930

7960

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

5 yr. 5 mo.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Eastern Shore State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Berlin

d. STREET ADDRESS

22X-1

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

July

18

19 60

S. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Female

White

WIDOWED

DIVORCED

3-11-11

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Handy Hadder, Maryland

14. MOTHER'S MAIDEN NAME

Addie Kelly, Maryland

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Eastern Shore State Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pneumonia

INTERVAL BETWEEN
ONSET AND DEATH

16 days

493X
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.
(b)
DUE TO
(c)
DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 7-1-59 19 60 to 7-18 19 60, that (I) (we) last saw the deceased alive on 7-18 19 60, and that death occurred at 1:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE

George H. Longley

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
7-18-60

22c. PHYSICIAN'S
NAME (Type)

George H. Longley, M.D.

22d. ADDRESS

Eastern Shore State Hospital
Cambridge, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town, or county)

(State)

BERLIN

MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE

Anna A. Burbage Berlin Md

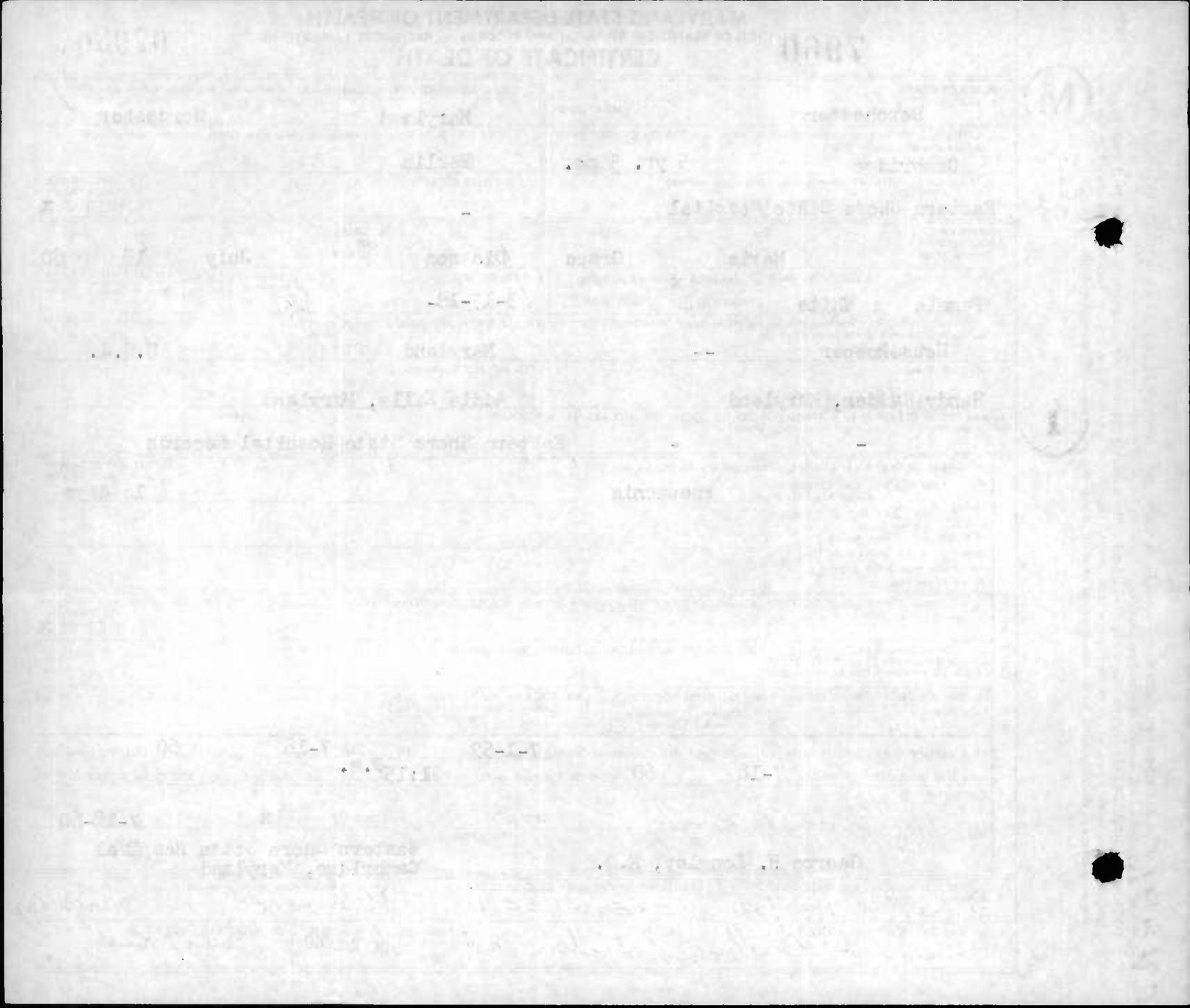
ADDRESS

25a. REC'D BY REGISTRAR

JUL 22 '60

25b. REGISTRAR'S SIGNATURE

Arthur S. French



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07931

Reg. Dist. No.

7961

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Petersburg		d. STREET ADDRESS Petersburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Robert	Middle Lester	Last Dixon	4. DATE OF DEATH	Month July	Day 2	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 17, 1907	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Dixon				14. MOTHER'S MAIDEN NAME Nettie J. Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Nettie J. Dixon, Hurlock, Maryland, R.F.D.	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED July 2, 1960					
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery		22d. LOCATION (City, town, or county) Near Hurlock, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Krause	

RECORD OF EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09052

7962			
1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock RFD		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles		First Millburn	Middle Fletcher, Jr.
S. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Hurlock, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Millburn Fletcher		14. MOTHER'S MAIDEN NAME Alice LaRue Fletcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Charles Fletcher, Hurlock - RFD, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from July 8 1960 to July 8 1960 that (I) (we) last saw the deceased alive on July 8 1960 , and that death occurred at 9 PM , from the causes and on the date stated above.		22b. DATE SIGNED 8/10/60	
22a. SIGNATURE Jason Yeeus		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS Hurlock, Maryland
22c. PHYSICIAN'S NAME (Type) Dr. Jason Yee, Hurlock, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-9-60	
23c. NAME OF CEMETERY OR CREMATORIAL Washington Church		23d. LOCATION (City, town, or county) (State) Hurlock, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Sampson, Hurlock, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE 8-17-60
			25b. REGISTRAR'S SIGNATURE _____ John E. Price

FilmG269 8-17-60,et
Stillbirth instead of death certificate sent in for this child .

1
FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7963

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07932

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester, Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood, Maryland.		c. LENGTH OF STAY IN 1b 10 Years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Linkwood, Maryland.		d. STREET ADDRESS None		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH 7	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1874.		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Nettie Todd., Cambridge, Maryland.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7824 Myocardial failure						INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.		DUE TO DUE TO DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Spedden, Maryland	(County) Cambridge	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr. M. D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) John Mace Jr. M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/11/60 Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/1960.	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Spedden Cemetery	22d. LOCATION (City, town, or country) Spedden, Maryland		(State)		
23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Maryland		24a. REC'D BY REGISTRAR JUL 26 '60 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Strand</i>						

RECORDED INFORMATION
ON THIS PAGE IS UNCLASSIFIED

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 12/12/17 BY SP/SP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7947

CERTIFICATE OF DEATH

Reg. Dist. No. 17933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 18	
3. NAME OF DECEASED (Type or print) Annie Jane Mae Harris		First	Middle
		Last	4. DATE OF DEATH July 19, 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.
13. FATHER'S NAME Joseph Meekins		14. MOTHER'S MAIDEN NAME Sarah Meekins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-9748	17. INFORMANT Frances Harris, Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 692.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days. Acute Myocardial Infarction Abscess, Lower Abdominal Wall 3 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) _____	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, M.D., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hurlock Medical Center	
ACTUAL SIGNATURE <i>Jason F. Yeomans</i>	DATE SIGNED <i>July 19, 1960</i>		
PHYSICIAN'S NAME (Type) <i>JASON F. YEOMANS, M.D.</i>	HURLOCK MARYLAND 730/1960		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/24/1960	22c. NAME OF CEMETERY OR CREMATORIAL Linas Road Cemetery	22d. LOCATION (City, town, or county) Dorchester Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb M. Clark Jr.</i>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR Arthur S. Mann	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Mann</i>
VS A15 (4) 15M 9/55		DATE AUG 5 '60	

WYOMING STATE DEPARTMENT OF HEALTH - SEISMIC

CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD J. COOPER	60	M	ACUTE CARDIOPULMONARY FAILURE
DATE OF DEATH		TIME OF DEATH	
APRIL 20, 1968		10:00 A.M.	
PLACE OF DEATH		TIME OF DEATH	
HOME		10:00 A.M.	
NAME AND ADDRESS OF PHYSICIAN		NAME AND ADDRESS OF HOSPITAL	
DR. RICHARD L. COOPER 101 E. 25TH ST. CHEYENNE, WYOMING		N/A	
NAME AND ADDRESS OF FUNERAL DIRECTOR		NAME AND ADDRESS OF CEMETERY	
N/A		N/A	
NAME AND ADDRESS OF PERSON FURNISHING THIS CERTIFICATE		SIGNATURE	
DR. RICHARD L. COOPER 101 E. 25TH ST. CHEYENNE, WYOMING		RICHARD L. COOPER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

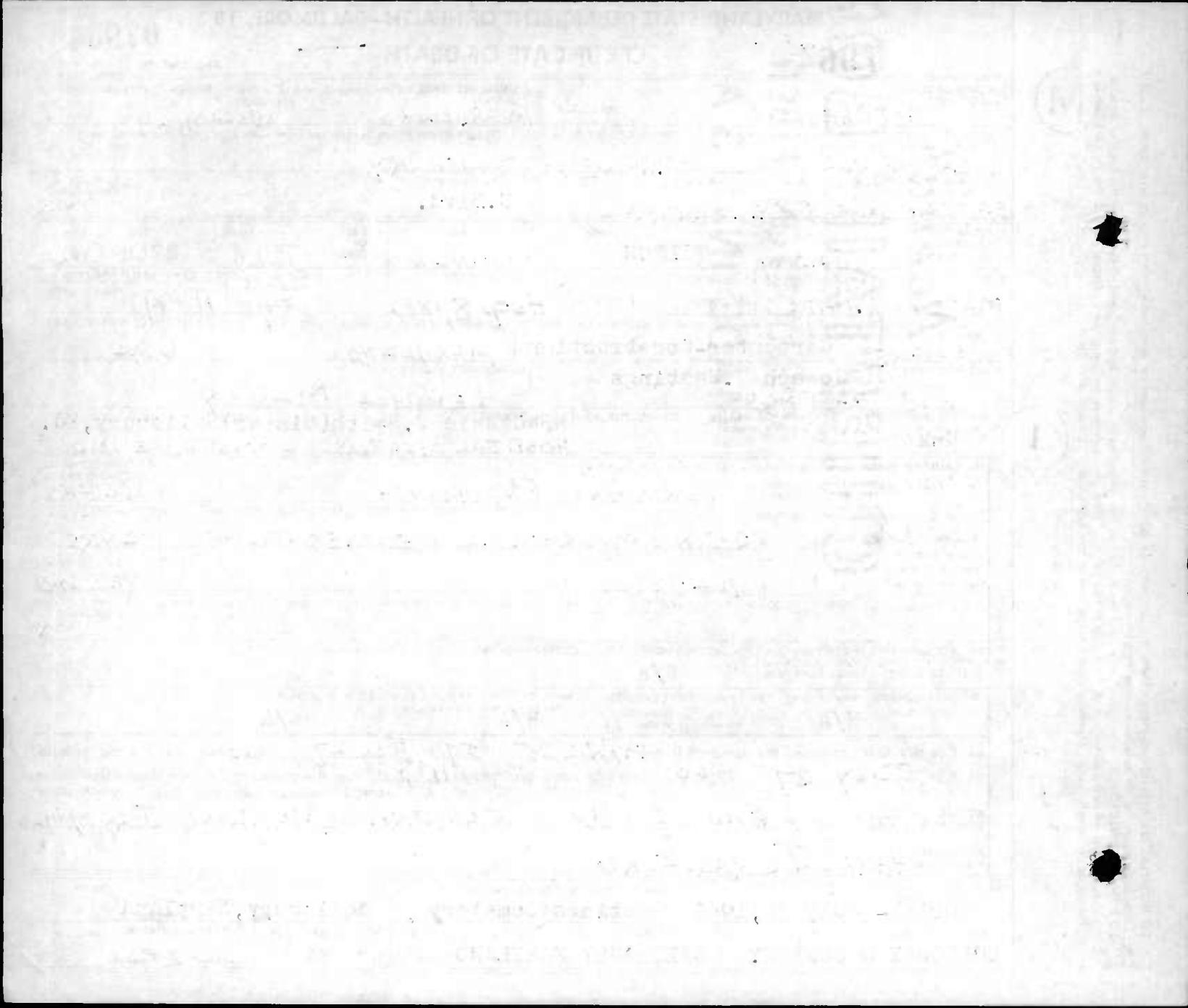
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07934

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 32 yrs - 10 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) EASTERN SHORE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	
d. STREET ADDRESS S.Bldv.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMORY		First TILTON	Middle HASTINGS
4. DATE OF DEATH JULY 27th 1960		Month JULY	Day Year 27th 1960
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 8 1882		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Carpenter-Construction	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph W. Hastings		14. MOTHER'S MAREN NAME LEVINIA MASSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. INFORMANT Mr. Cassie C. Smith (Sister) Salisbury, Md.	
17. HOSPITAL RECORDS CAMBRIDGE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL PNEUMONIA			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC Myocardial DEGENERATION			
DUE TO (c) DIABETES			
INTERVAL BETWEEN ONSET AND DEATH 48 HRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that I attended the deceased from APRIL 25, 1957 , to July 27, 1960 that I last saw the deceased alive on July 27, 1960 , and that death occurred at 11 a.m. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Cambridge, Maryland			
DATE SIGNED July 27, 1960			
ACTUAL SIGNATURE Harry J. Crawford M.D. CAMBRIDGE, MARYLAND			
PHYSICIAN'S NAME (Type) HARRY J. CRAWFORD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Hastings Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE AUG 1 '60			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

L. Maryanoff

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G209 8-23-60 et

7965

CERTIFICATE OF DEATH

Reg. Dist. No.

07935

1. PLACE OF DEATH a. COUNTY Dorchester Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seward's, Maryland.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Curtis Insley		First	Middle
		Last	4. DATE OF DEATH Month Day Year 7 3 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1896.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food	11. BIRTHPLACE (State or foreign country) Dorchester Co. Maryland.
13. FATHER'S NAME William Insley		14. MOTHER'S MAIDEN NAME Mollie Abbott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-6525	17. INFORMANT Mrs. Curtis Insley, Seward's, Maryland.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (o) 321X		INTERVAL BETWEEN ONSET AND DEATH 21 days	
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 136 Race St
20f. (City or town) Baltimore		(County) Maryland	(State) Md.
21. I certify that I attended the deceased from 6/10 , 19 64 to 7/13 , 19 60 , that I last saw the deceased alive on 7/16/60 , 19 60 , and that death occurred at 2 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lawrence Maryanoff</i>	ADDRESS (Street, city or town, state) 136 Race St		DATE SIGNED 7/16/60
PHYSICIAN'S NAME (Type) Lawrence Maryanoff	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF 7/6/1960	22c. NAME OF CEMETERY OR CREMATORIAL Family Burial Lot.	22d. LOCATION (City, town, or county) Seward's, Maryland.	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ie Compte Funeral Service, Cambridge, Maryland</i>	ADDRESS	24a. REC'D BY REGISTRAR Arthur S. Krause	24b. REGISTRAR'S SIGNATURE
		DATE JUL 8 '60	

85 BROMITIUS—HATCH TO THE STATE GRANARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7966

CERTIFICATE OF DEATH

Reg. Dist. No.

07936

1. PLACE OF DEATH a. COUNTY DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN 1b 16 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRAPPE		d. STREET ADDRESS NONE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSP.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BESSIE		First S	Middle JENKINS	Last JENKINS	4. DATE OF DEATH JULY 25, 1960	Month JULY	Day 25	Year 1960	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1882	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN SIMPLER				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222-12-4545		17. INFORMANT JENKINS, COURTNEY		Address TRAPPE, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE		DUE TO 420							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ARTERIOSCLEROTIC HEART DISEASE		(b) DUE TO 16 mos. +							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from JULY 1, 1959 , to JULY 25, 1960 , that I last saw the deceased alive on JULY 24, 1960 , and that death occurred at 2:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE George H. Longley		M.D. RED 2		ADDRESS (Street, city or town, state) CAMBRIDGE, Md.		DATE SIGNED JULY 25, 1960			
PHYSICIAN'S NAME (Type) GEORGE H. LONGLEY									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Denton		22d. LOCATION (City, town, or county) Denton		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John George Moore & Son		ADDRESS Denton		24a. REC'D BY REGISTRAR DATE JUL 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

87. ЗНОВУТЬЯ-ШІАМ ІО ТЕМНІЧАБО СТАЛС ОНДІЛІЧАМ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7948

Item 9 FilmG268 8-5-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

07937

1. PLACE OF DEATH o. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN 1b 3 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Reba	Middle Hubbard	Last Knox
4. DATE OF DEATH	Month 7	Day 11	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/1992
9. AGE (In years last birthday) 68 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Housewife	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Hubbard	14. MOTHER'S MAIDEN NAME Mary Bennett	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. John Knox, Cambridge, Maryland,	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER CERVIX UTERI 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 200 Maryland Avenue
20f. (City or town) Cambridge, Maryland		(County)	(State)
21. I certify that I attended the deceased from 3-15-60 , 19 60 , to 7-14-60 , 19 60 , that I last saw the deceased alive on 7-14-60 , 19 60 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Albert E. Bunker</i>			
ADDRESS (Street, city or town, state) 200 Maryland Avenue			
DATE SIGNED 7-16-60			
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M.D.		CAMBRIDGE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/1960.	22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery
22d. LOCATION (City, town, or county) Cambridge, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland		24a. REC'D BY REGISTRAR DATE JUL 26 '60	24b. REGISTRAR'S SIGNATURE Arthur J. Russ

8 СЕПТЕМБРЯ – ИДАЙ ВО ТВОРЧЕСТВО СТАЗЫ ОГЛЯДЫ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07938

7949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.E.D. # 2, Cambridge, Maryland.	
3. NAME OF DECEASED (Type or print) Carrie		First Kirch	Middle Kuebler
4. DATE OF DEATH 7 3 1960		Month 7	Day 3
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH 4/14/1878		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. Henry Kuebler, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
cerebral Hemorrhage generalized Arteriosclerosis 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/2 , 19 60 to 7/3 , 19 60 , that I last saw the deceased alive on 7/3/60 , 19 60 , and that death occurred at 4:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryland M.D.		ADDRESS (Street, city or town, state) 136 Race St DATE SIGNED 7/5/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/1960.	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park.
22d. LOCATION (City, town, or county) Cambridge, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUL 8 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07939

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Chestertown		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 5 Mo's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		d. STREET ADDRESS 05x-a		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Ruby	Middle Q.	Last Lackey	4. DATE OF DEATH JULY 17 1960	Month	Day	Year	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 26 1895	9. AGE (In years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME A.S. Lackey		14. MOTHER'S MAIDEN NAME SARA Elizabeth Warren		Address Hospital records Cambridge Md				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 17. INFORMANT Hospital records								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage INTERVAL BETWEEN ONSET AND DEATH UNK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb 23, 1960 , to July 17, 1960 , that I last saw the deceased alive on July 16, 1960 , and that death occurred at 110A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED 7-17-60								
ACTUAL SIGNATURE Thomas J. Dredge M.D.								
PHYSICIAN'S NAME (Type)		PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19-60		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) Seaford Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1661-94 Hope Ridge		ADDRESS next page		24a. REC'D BY REGISTRAR Arthur S. Krause		24b. REGISTRAR'S SIGNATURE		
VS A15 (4) 15M 9/SS		DATE JUL 19 '60						

BY JEFFREY BROWN - BLOOMBERG NEWS - THE MONTGOMERY STATE CHAMBER

7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7968

CERTIFICATE OF DEATH

07940

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		d. STREET ADDRESS Easton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fisher Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First EDITH	Middle LEWIS	Last Lewis	4. DATE OF DEATH July 2, 1960	Month July	Day 2	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 23, 1871		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.W.		
13. FATHER'S NAME Albert G. Hall		14. MOTHER'S MAIDEN NAME Caroline Choate		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Carol Muir		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerosis - generalized -		DUE TO (b)		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Easton, Maryland		(County)		(State)		
21. I certify that I attended the deceased from 7-11 , 19 60 , to July 2 , 19 60 , that I last saw the deceased alive on 7-11 , 19 60 , and that death occurred at 12-14 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) William L. Winters, M.D. 210 E. Dover, Easton, Md. 1960								
ACTUAL SIGNATURE William L. Winters, M.D.								
DATE SIGNED 1960								
PHYSICIAN'S NAME (Type) Dr. William L. Winters		Dover St.		Easton, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery		22d. LOCATION (City, town, or county) Easton, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son								
ADDRESS Easton, Md.				24a. REC'D BY REGISTRAR DATE JUL 7 '60				
				24b. REGISTRAR'S SIGNATURE Charles S. Traub				

MANUFACTURE DEPARTMENT OF HAZELNUT - BALTIMORE 18

CERTIFICATE OF DEATH

Date of Birth

Sex

Cause of Death

Name

Place of Death

Age

Race

Time of Death

Date of Death

Date of Birth

Cause of Death

Place of Death

Cause of Death

Place of Death

Date of Birth

Cause of Death

Place of Death

Age

Race

Time

Date

Date of Birth

Cause of Death

Place of Death

Date of Birth

Cause of Death

Place of Death

Date of Birth

Cause of Death

Place of Death

Date of Birth

Cause of Death

Place of Death

Date of Birth

Cause of Death

Place of Death

Date of Birth

Cause of Death

Place of Death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7969

CERTIFICATE OF DEATH

Reg. Dist. No.

07941

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock, R.F.D., Md.		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock, Maryland.		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Meda		First A.	Middle Liber	Last 7	Month 15	Day 19	Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/5/1890.	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 15	Hours 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Guelph, Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William C. Langtry				14. MOTHER'S MAIDEN NAME Anna C. Messenger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. George Austin, R.R.D., Hurlock, Maryland.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of body of pancreas with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 year (3) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1 Locust St	20f. (City or town) Cambridge, MD	(County) Maryland	(State) MD
21. I certify that I attended the deceased from July 2-8 , 1959, to July 15 , 1960, that I last saw the deceased alive on July 13 , 1960, and that death occurred at 11:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE: Lewis M. Burdette M.D. PHYSICIAN'S NAME (Type): Lewis M. Burdette ADDRESS: 1 Locust St ADDRESS (Street, city or town, state) DATE SIGNED								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/17/1960.	22c. NAME OF CEMETERY OR CREMATORIUM Christ Episopial Chruch	Iard	22d. LOCATION (City, town, or county) Cambridge, Maryland	(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland		ADDRESS Le Compte Funeral Service, Cambridge, Maryland	24a. REC'D BY REGISTRAR JUL 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Pease			

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07942

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXXXXX		d. STREET ADDRESS BIVALVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Josephine	Middle Malone	Last	4. DATE OF DEATH	Month July	Day 1	Year 1960
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	DATE OF BIRTH 9/3/1875		9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland & Salisbury		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME S. Thomas Disharoon		14. MOTHER'S MAIDEN NAME Mary Ellen White					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Ernest J. Disharoon (Nephew) Ave. Hospital records		Address 177B' Roseberry, Cambridge	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Cerebral Haemorrhage		Salisbury, Maryland		INTERVAL BETWEEN ONSET AND DEATH UNK	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a. p. N/A 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) N/A (State)	
21. I certify that I attended the deceased from April 1, 1960, to July 1, 1960, that I last saw the deceased alive on July 1, 1960, and that death occurred at 10:22 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 7-1-60							
PHYSICIAN'S NAME (Type) Thomas J. Dredge							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7/3/60		22b. DATE THEREOF 7/3/60		22c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND		24a. REC'D. <input type="checkbox"/> REG'D. <input type="checkbox"/> 5/30/60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7950

Item 16 film G269 8-15-60 et

CERTIFICATE OF DEATH

17943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) William		First	Middle
		Last	Marine
4. DATE OF DEATH July 21, 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 15, 1902
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Dorchester County, Md.
13. FATHER'S NAME Joseph Dudley		14. MOTHER'S MAIDEN NAME Alverta Marine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-8421	17. INFORMANT Elzey Marine, Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1, 1960 , to July 21, 1960 , that I last saw the deceased alive on July 21, 1960 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md.			
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		DATE SIGNED 7-25-60	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/1960	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert W. Solle</i>		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE AUG 5 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

WISCONSIN STATE DEPARTMENT OF HEALTH - SALINOWNE, WI

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7951

CERTIFICATE OF DEATH

117944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Toddville, Maryland.		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Webster		First W.	Middle Meredith	Last 7	4. DATE OF DEATH 19 19 60	Month 7	Day 19	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1/25/1881	9. AGE (In years lost birthday) yrs. 76	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Store Keeper		11. BIRTHPLACE (State or foreign country) Toddville, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Asbury C. Meredith				14. MOTHER'S MAIDEN NAME Derinda Todd				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-1057		17. INFORMANT Mrs. Lula Meredith, Toddville, Maryland.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX DUE TO <i>Cerebral Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH 7/4/60								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerosis</i> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SP		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7/4/60 to 7/19/60 , that I last saw the deceased alive on 7/19/60 , and that death occurred at SP M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust St DATE SIGNED 7/22/60								
ACTUAL SIGNATURE 		M.D. W.H. Hanks M.D.						
PHYSICIAN'S NAME (Type) W.H. Hanks M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/1960		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.		
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.		ADDRESS Le Compte Funeral Service, Cambridge, Maryland.		24a. REC'D BY REGISTRAR DATE AUG 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87 39011-8719 80 MARYLAND STATE POLICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7952

Items 8,9 Film G268 8-5-60 et

07945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Dorchester, Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN 1b 9 Days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aireys, Maryland.		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) J. Walter Neal Sr.		First	Middle	Last	4. DATE OF DEATH 7	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 12/1/1889 / 1887 73 12	9. AGE (In years lost birthday) yrs. 73 12	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Neal				14. MOTHER'S MAIDEN NAME Josephine Wheatley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Joseph Neal, Aireys, Maryland.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 9 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 44-51		DUE TO with Hemiplegia - Left -						
		DUE TO (b)						
		DUE TO (c) Hypertension cardiac vascular Disease						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____ 6-21-49 _____, 19_____, to 7-12-60 _____, 19_____, that I last saw the deceased alive on _____ 7-11-60 _____, 19_____, and that death occurred at 6 AM M, from the causes and on the date stated above. ACTUAL SIGNATURE Albert E. Bunker				ADDRESS (Street, city or town, state) 200 Maryland Avenue		DATE SIGNED 7-13-60		
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/1960		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		ADDRESS		24a. REC'D BY REGISTRAR Jul 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knott		

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	DEATH DATE
WILLIAM H. COOPER	65	M	CHRONIC CARDIOPNEUMONIC DISEASE	APRIL 20, 1958
ADDRESS OF DECEASED				
1015 E. 36TH ST., BALTIMORE, MD.				
NAME AND ADDRESS OF PHYSICIAN				
DR. JAMES C. COOPER, 1015 E. 36TH ST., BALTIMORE, MD.				
NAME AND ADDRESS OF FUNERAL DIRECTOR				
J. W. COOPER, 1015 E. 36TH ST., BALTIMORE, MD.				
NAME AND ADDRESS OF PERSON REPORTING				
DR. JAMES C. COOPER, 1015 E. 36TH ST., BALTIMORE, MD.				
TIME OF DEATH				
10:00 A.M.				
TIME OF AUTOPSY				
10:00 A.M.				
NAME AND ADDRESS OF PERSON SIGNING				
DR. JAMES C. COOPER, 1015 E. 36TH ST., BALTIMORE, MD.				
SIGNATURE				
JAMES C. COOPER				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7953 CERTIFICATE OF DEATH

07947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN 1b 5 Days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cornerville, Maryland.		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Milton	Middle Davis	Last North	4. DATE OF DEATH 7	Month 10	Day 10	Year 1960	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/1887	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY School Board		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin North				14. MOTHER'S MAIDEN NAME UnKnown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Milton North, Cornerville, Maryland.....		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac and Renal Failure INTERVAL BETWEEN ONSET AND DEATH 18 hours 334X DUE TO B-1 - Embolus left femoral artery 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) B-2 - Hemiplegia, right 20 days (c) Arteriosclerosis, generalized unknown								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, mild - (known 3 years)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- - - - 19 p. m. ---		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) --- - - - (County) (State)		
21. I certify that I attended the deceased from 6-20-60 , 19, to 7-10-60 , 19, that I last saw the deceased alive on 7-10-60 , 19, and that death occurred at 2:58 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 15 Locust Street, Cambridge, Md. 7-11-0								
DATE SIGNED Eldridge H. Wolff								
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/1960.		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland.		
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service		ADDRESS Cambridge, Maryland		24a. REC'D BY REGISTRAR JUL 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Strand		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

84. АТОМНАЯ-ИДЕАЛНОСТЬ ПРИЧИНОВАНИЯ В СОСТАВЕ ОБЩЕСТВА

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7954

CERTIFICATE OF DEATH

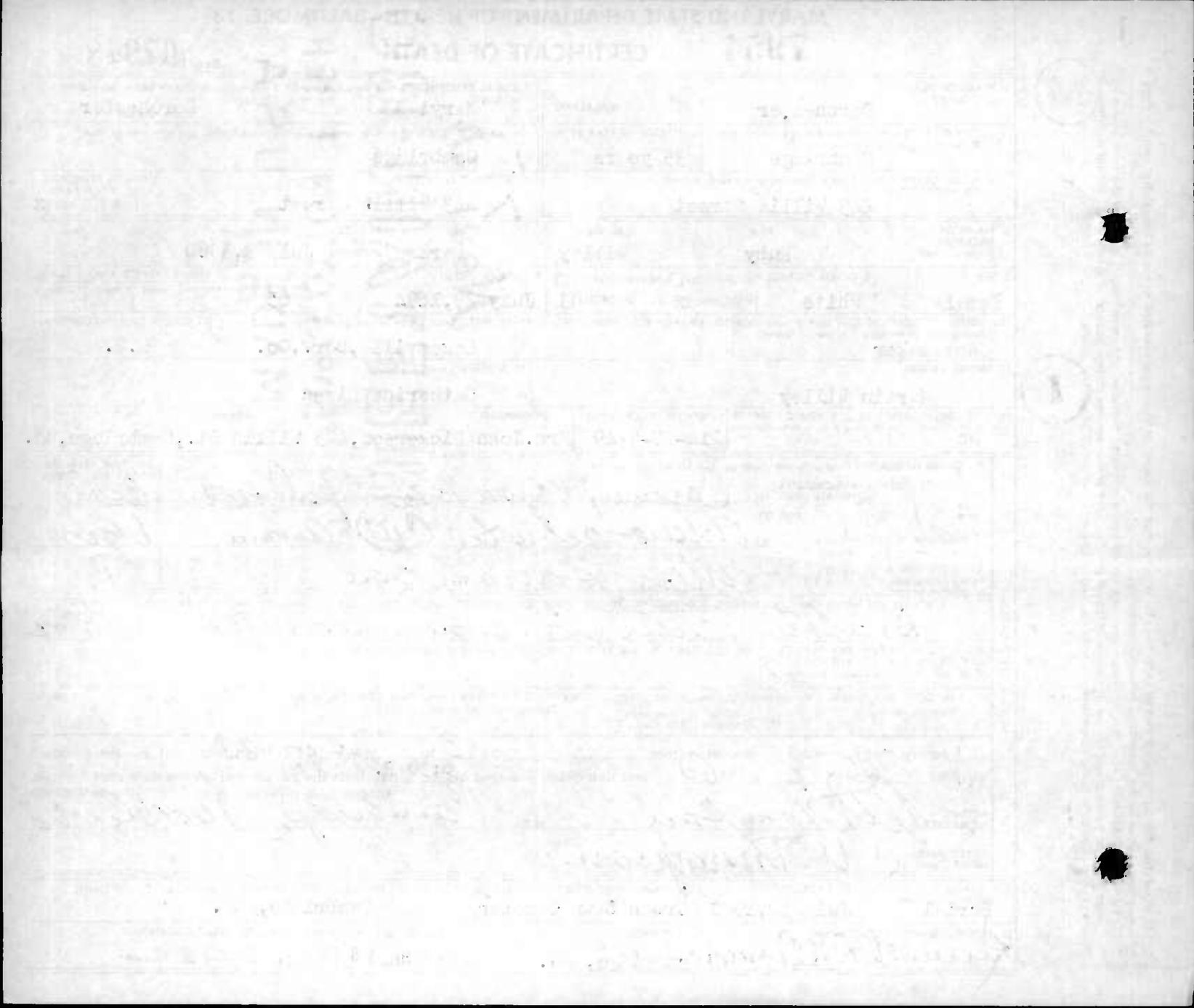
Reg. Dist. No. 07948

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 35 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 443 Willis Street		e. STREET ADDRESS 443 Willis Street		
3. NAME OF DECEASED (Type or print) Ruby		First Ruby	Middle Willey	
Last Parks		4. DATE OF DEATH July 9, 1960	Month Day Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 29, 1894	
		<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lakesville, Dor., Co.	
13. FATHER'S NAME Martin Willey		14. MOTHER'S MAIDEN NAME Catherine Dixon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-07-7249	INFORMANT Address Mrs. John Dickerson, 423 Willis St., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 428-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)				
<i>Coronary Thrombosis & pul. emb.</i> Acute				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterio-sclerotic CVD Angina</i> 6 yrs.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Diabetes mellitus - mod. sever, mucous coated</i>				
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1952 to July 9, 1960, that I last saw the deceased alive on July 8, 1960 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Maryland DATE SIGNED Arthur S. Kraus				
ACTUAL SIGNATURE <i>J. U. Thompson</i>		PHYSICIAN'S NAME (Type) J. U. Thompson.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Green Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Stevens</i>		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE JUL 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7971

CERTIFICATE OF DEATH

Reg. Dist. No.

07949

1. PLACE OF DEATH o. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wingate, Maryland.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wingate, Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jesse		First	Middle J.	Last Powley	4. DATE OF DEATH Month 7	Day 3	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/12/1872.		9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food		11. BIRTHPLACE (State or foreign country) Maryland, Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Powley				14. MOTHER'S MAIDEN NAME Rebecca Powley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. G. Powley, Wingate, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge	(County) Caroline	(State) Md.
21. I certify that I attended the deceased from 6/10 , 19 50 , to 7/3 , 19 60 , that I last saw the deceased alive on 7/3 , 19 60 , and that death occurred at P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 104 Locust St. Cambridge Md.							
ACTUAL SIGNATURE W.H. Hawks DATE SIGNED 7/5/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/1960.	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park.		22d. LOCATION (City, town, or county) Cambridge, Maryland.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland		ADDRESS Le Compte Funeral Service, Cambridge, Maryland	24a. REC'D BY REGISTRAR DATE JUL 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

WISCONSIN STATE DEPARTMENT OF HEALTH - DEATH CERTIFICATE

CERTIFICATE OF DEATH

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7955

CERTIFICATE OF DEATH

Reg. Dist. No. 2950

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 10hrs 55mins.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 7 Trenton Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Rosetta	Last Jr.	4. DATE OF DEATH July 26, 1960	Month July	Day 26	Year 1960
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1960	9. AGE (In years lost birthday) yrs. 10	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Days 55	Hours Min. 10 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles Rosetta, Jr.		14. MOTHER'S MAIDEN NAME Juanita Naomi Willey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT mother		Address 7 Trenton St. Cambridge	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] 776X PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Gummatus and Pneumatury (24 weeks gestation)							
INTERVAL BETWEEN ONSET AND DEATH 7 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/26 , 19 60 , to 7/26 , 19 60 , that I last saw the deceased alive on 7/26 , 19 60 , and that death occurred at 7:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE W. H. Hanks PHYSICIAN'S NAME (Type) W. H. Hanks							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/1960.		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7956

CERTIFICATE OF DEATH

07951
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Lillie	Middle Anne	Last Rumbley	
4. DATE OF DEATH	Month July	Day 13, 1960	Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1860	
9. AGE (In years lost birthday) 99 yrs.	10. IF UNDER 1 YEAR Months 99	11. IF UNDER 24 HRS. Days 99	12. Hours 99	
13. FATHER'S NAME Marcellus Slacum	14. MOTHER'S MAIDEN NAME Lovenia Keyes	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None	17. INFORMANT Carl Rumbley, 126 Glasgow St., Cambridge, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 5 YEARS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cambridge	(County) (State) MD
21. I certify that I attended the deceased from 13 FEB 1947 to 13 JULY 1960 , that I last saw the deceased alive on 12 JULY 1960 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>W.E. Gunby Jr.</i>	ADDRESS (Street, city or town, state) 105 Church St., Cambridge 2nd			
PHYSICIAN'S NAME (Type) W.E. Gunby Jr.	DATE SIGNED 18 JUN 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 16, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery	22d. LOCATION (City, town, or county) Cambridge, Md.	(State) MD
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Shewey</i>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE JUL 18 '60	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician and completely filed by the funeral director,
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

www.wiley.com/go/robinson/10.1002/9780470093732

07952

7972

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
Dorchester		Maryland		a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
East New Market, R.D.		56 years		X East New Market, R.D.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Rural		Rural					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year		
	William X	Frederick	Schlueter	July 20, 1960	19		
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	August 4, 1867	92	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
Retired Farmer self employed				Baltimore			
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME August Schlueter							
14. MOTHER'S MAIDEN NAME Louise Kreuger							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Address			
(If yes, give war or dates of service)		none		Edward A. Schlueter, East New Market, Md., R.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO <i>Carcinoma BLADDER</i> INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senility.</i> —							
DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/10/60</i> , 19 <i>59</i> , to <i>7/20/60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7/20/60</i> , 19 <i>60</i> , and that death occurred at <i>1:45 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>H. H. Hanks M.D.</i>						DATE SIGNED <i>7/21/60</i>	
PHYSICIAN'S NAME (Type) <i>W. H. Hanks M.D.</i>		<i>104 Locust St., Cambridge, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 22, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>East New Market Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>East New Market, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Horner</i>		ADDRESS <i>Cambridge, Md.</i>		24a. REC'D BY REGISTRAR DATE JUL 25 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Horner</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYANDOTTE COUNTY



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7957

CERTIFICATE OF DEATH

07953

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland.		b. COUNTY Dorchester, Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN 1b 1 Day		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anderws, Maryland.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Maryland Hospital.		d. STREET ADDRESS None		d. DATE OF DEATH 7 26 1960		Month Day Year		
3. NAME OF DECEASED (Type or print) William T. Shorter		First	Middle	Last	Month	Day	Year	
4. SEX Male		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	7. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1889	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Halen Shorter		14. MOTHER'S MAIDEN NAME Saphronie Burton		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Gladys Wetzel, 5407 Bartran Dr., Phila.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 day				
		Cerebral Hemorrhage						
		Cerebral Arteriosclerosis				1 yr.		
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7/19 , 19 60 to 7/26/60 , 19 60 , that I last saw the deceased alive on 7/22 , 19 60 , and that death occurred at 7/26/60 M, from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Race St						DATE SIGNED 7/26/60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/1960		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

91. ЗЛОУПРАВЛЯЮЩИЕ ОРГАНЫ ПО ТЕХНИЧЕСКОМУ РЕГУЛИРОВАНИЮ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07954

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood, Maryland.		c. LENGTH OF STAY IN 1b 16 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood, Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Reginald	Last Spedden	4. DATE OF DEATH 5/4/1873	Month 7	Day 17	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/1873	9. AGE (in years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Hudson, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wrightson Spedden				14. MOTHER'S MAIDEN NAME Clara Soedden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Reginald Spedden, Cambridge, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR RENAL DISEASE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ARTERIOSCLEROSIS 5 YEARS DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cambridge	(County)	(State)
21. I certify that I attended the deceased from 5/18/1948 to 7/17/1960 , that I last saw the deceased alive on 6/16/1960 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE J. E. Gunby Jr. M.D. ADDRESS (Street, city or town, state) 105 Church St. DATE SIGNED 7/18/60 PHYSICIAN'S NAME (Type) W. E. GUNBY JR. Cambridge Med.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/19/1960.	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery	22d. LOCATION (City, town, or county) Cambridge, Maryland.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.				ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 26 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Thrall.	

STATE OF CALIFORNIA—SAFETY OF DRUGS

1

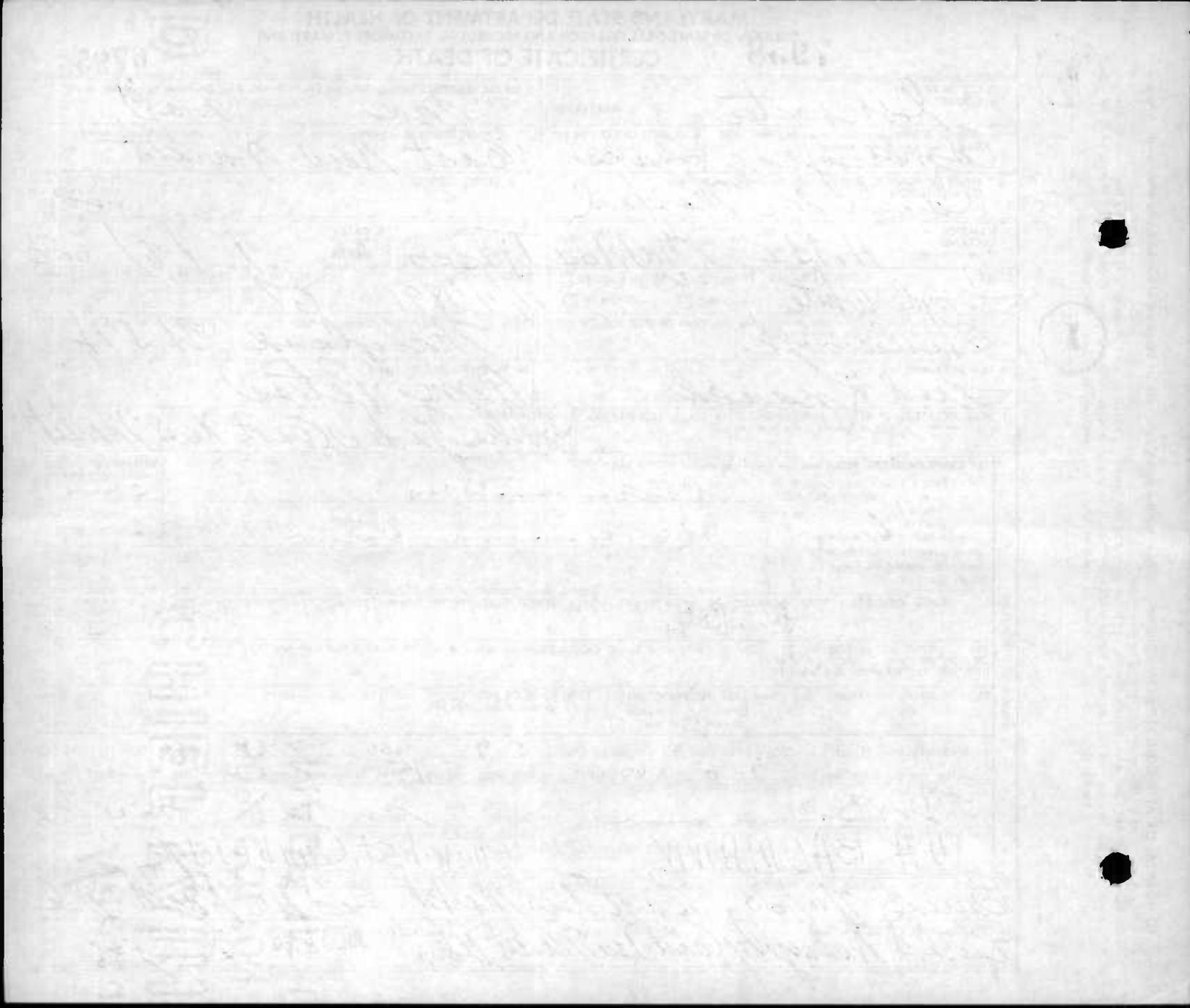
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Dorchester</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
<i>Cambridge</i>	<i>Zuks</i>	<i>Day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Cambridge Maryland</i>	<i>East New Market</i>		
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
<i>H. Ida Malida Tjaden</i>		Month	Day
First	Middle	7	18
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
<i>Female</i>	<i>white</i>	<i>WIDOWED</i> <input type="checkbox"/>	<i>11/4/1891</i>
DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs.		12. CITIZEN OF WHAT COUNTRY?
	88	IF UNDER 1 YEAR	<i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	IF UNDER 24 HRS.
<i>Housewife</i>		<i>Maryland</i>	Months Days Hours Min.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Fred Knaack</i>	<i>Agnes Peters</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		<i>Josie Tjaden, East New Market</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>154X</i>			
DUE TO			
<i>Carcinomatosis</i>			
2. mos			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
<i>Adenocarcinoma Rectum</i>			
2. mos			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Diabetes</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <i>5-9 1960</i> to <i>7-5 1960</i> , that (I) (we) last saw the deceased alive on <i>7-8 1960</i> and that death occurred at <i>145 M</i> , from the causes and on the date stated above.			
22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
<i>W.H. BAUMANN</i>			<i>7-11-60</i>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
		<i>Church St, Cambridge</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM
<i>Burial 7/11/60</i>			<i>East New Market</i>
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	25a. REC'D BY REGISTRAR
<i>Fuller J. Trullaghy, East New Market, Md.</i>			<i>JUL 15 '60</i>
		DATE	25b. REGISTRAR'S SIGNATURE
			<i>Arthur S. Knob</i>



FOR STATE
HEALTH DEPT.

If necessary, please
call the funeral director. Page
_____ named for your files.
The Board of Health,
[redacted] _____
Death.

FOR STATE 7974 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 17956

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS 1437-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S.State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Blanche	Middle Mae	Last Wilson		4. DATE OF DEATH July 23, 1960	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/92		9. AGE (in years from birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Mogle				14. MOTHER'S MAIDEN NAME Anna Compton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Records E.S.S. Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO 903.7 Conditions, if any, which gave rise to immediate cause (b) (c), staining the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck right femur DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 days							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor in hospital			
20c. TIME OF INJURY 11 AM Month, Day, Year a.m. 5-11 1960 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Cambridge	(County) Dor. (State) Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John Mace Jr. DATE SIGNED 7/23/60							
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 7/26/60		22b. DATE THEREOF 7/26/60		22c. NAME OF CEMETERY OR CREMATORIUM Memorial Park		22d. LOCATION (City, town, or county) Easton (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 26 '60		24b. REGISTRAR'S SIGNATURE Charles S. Knue	

STATE OF
TENNESSEE

DEPARTMENT OF STATE - TENNESSEE
MEDICAL EXAMINER'S OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 1 Form 207 7-19-60 et

07957

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edith	Middle Insley	Last Wroten
4. DATE OF DEATH	July 12	Month	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-20-75
9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin Asbury Insley		14. MOTHER'S MAIDEN NAME Amanda Pritchett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-01-4963	17. INFORMANT Eastern Shore State Hospital records.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		DUE TO Bronchopneumonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		DUE TO Cerebral hemorrhage 2 days +	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-11 1960 to 7-12 1960, that (I) (we) last saw the deceased alive on 7-12 1960, and that death occurred 7:15 PM from the causes and on the date stated above.			
22a. SIGNATURE George E. Currier		22b. DATE July 12, 1960	
22c. PHYSICIAN'S NAME (Type) George E. Currier, M.D.		22d. ADDRESS Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/15/60	
23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tickner Funeral Home, Baltimore, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR	
		DATE JUL 14 '60	
		25b. REGISTRAR'S SIGNATURE Clinton S. Thomas	

1881

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